

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-035132

STATE FILE NUMBER

Registration District No. **042** Primary Registration District No. **1000** Registrar's No. **1134**

FILED SEP 25 1963

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
Length of stay in 1b 9 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 413 No. 4 St.		d. STREET ADDRESS (If outside, give location) 413 No. 4 St.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First CHARLES Middle FRANKLIN Last BAKER			4. DATE OF DEATH Month Sept. Day 19 Year 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/15/1895	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (City and state or country) Afton Oklahoma	
12. CITIZEN OF WHAT COUNTRY U S A		13a. FATHER'S NAME William Baker		13b. MOTHER'S MAIDEN NAME Emma Brooks	
14. NAME OF HUSBAND OR WIFE Ethel M Baker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT Mrs. Ethel Baker		Address St. Joseph Mo.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	

IMMEDIATE CAUSE (a) At. and Cl. embolism failure		INTERVAL BETWEEN ONSET AND DEATH 6 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerotic cardiovascular disease		8 yrs
DUE TO (c) [REDACTED]		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) auricular fibrillation		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 2:15 a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	Month, Day, Year 9-9-63	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) St. Joseph		20f. CITY, TOWN, OR LOCATION St. Joseph	
20g. COUNTY Missouri		20h. STATE Missouri	

21. I attended the deceased from **9-9-63** to **9-19-63** and last saw him alive on **9-19-63**
Death occurred at **2:15 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature]	(Degree or title) MD	22b. ADDRESS 702 Yale, St. Joseph, Mo	22c. DATE SIGNED 9-23-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/21/1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph Missouri
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24. FUNERAL DIRECTOR [Signature]	ADDRESS St. Joseph Mo	25. DATE RECD. BY LOCAL REG. Sept. 23, 1963	26. REGISTRAR'S SIGNATURE [Signature]
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(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

P.L. Maginn, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

Permit issued 9-20-63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.